OR

WOMENS HEALTH IN NORWAY

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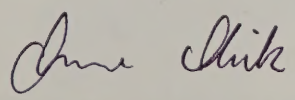
PREFACE

This report on women's health in Norway is written for the Fourth International Women's Conference, in Beijing in September 1995. It is prepared as a contribution to an international dialogue on this politically sensitive issue. In particular reproductive matters, which are so crucial to women's overall health, touch upon fundamental moral and religious issues, and are heavily debated in every country. The report therefore discusses reproductive health in some depth. But also other aspects of women's health can be controversial, as it is often a matter of women gaining more control and power.

I hope this report of women's health in Norway will provide inspiration and ideas for others. I want to thank Dr. Berit Austveg for writing the report, and Dr. Berit Schei for supervising the work. The Norwegian Board of Health is cooperating with the World Health Organization in gathering information on women's health, and this report is part of that cooperation. The content of this report is the responsibility of the author.

Oslo, August 1995



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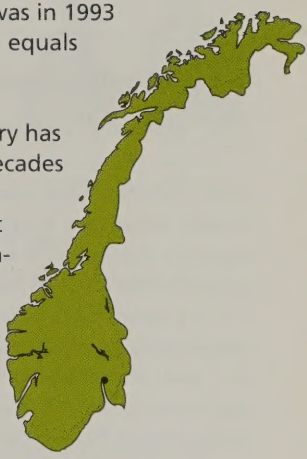
CONTENTS:

NORWAY: THE COUNTRY AND THE PEOPLE, IN A GLIMPSE

Norway borders Sweden, Finland and Russia on the east, and has a very long coast and deep fjords, with great variations in climatic conditions. With 4.3 million inhabitants and a total area of 386,958 square kilometres, Norway is a scarsely populated country. Large parts of the country cannot be inhabited due to mountains and glaciers. People tend to live in the lower inland, where there has traditionally been farming, and along the coast, where people have lived from fishing. There is a strong political will to maintain a decentralized population structure.

An abundance of waterfalls has provided cheap electrical power, and has for a long time been an asset to the country's economy. Since 1960s, oil production in the North Sea has been a major source of foreign exchange. Gross National Product per capita was in 1993 NOK 164,853, which equals US Dollars 25,000.



Politically the country has been stable, with decades of Labour Party rule interrupted by short periods of non-socialist coalition governments. Traditionally there has been a strong cooperation with the other Nordic countries: Denmark, Sweden, Finland and Iceland. In 1972 and 1994 a referendum was held on joining the European Community, and both times it was turned down, with small margins.

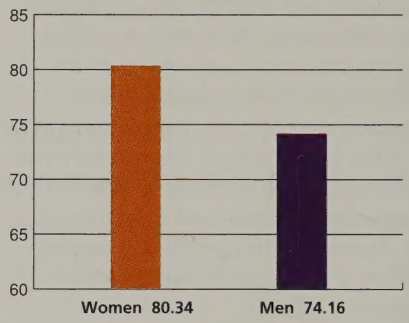
1. HEALTH AND SOCIAL CONDITIONS OF WOMEN IN NORWAY

1.1 Vital statistics, morbidity

1.1.1 Women live longer than men.....

Vital statistics have a long tradition as health indicators. From these data, it appears that women in Norway are advantaged vis-à-vis men: as far back in history as we have reliable data, women have had a lower mortality than men, and this goes for all age groups. Presently, life expectancy at birth is approximately six years longer for women than for men.

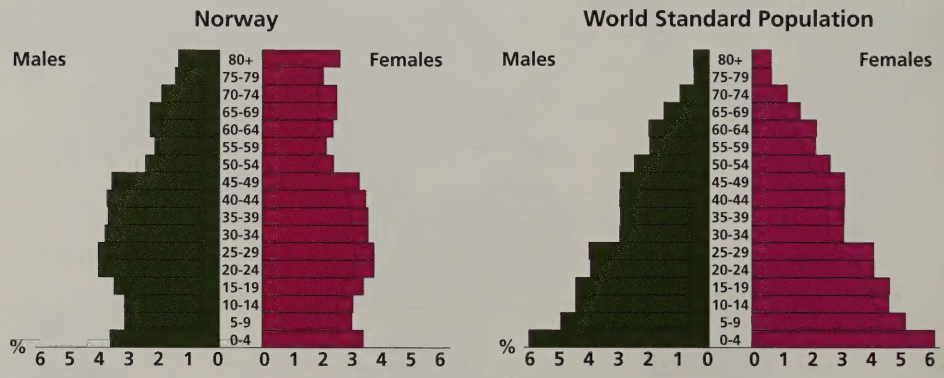
Life expectancy at birth



Source: Statistics Norway, 1994

Compared to the world at large, the population «pyramid» therefore has less of a pyramid shape.

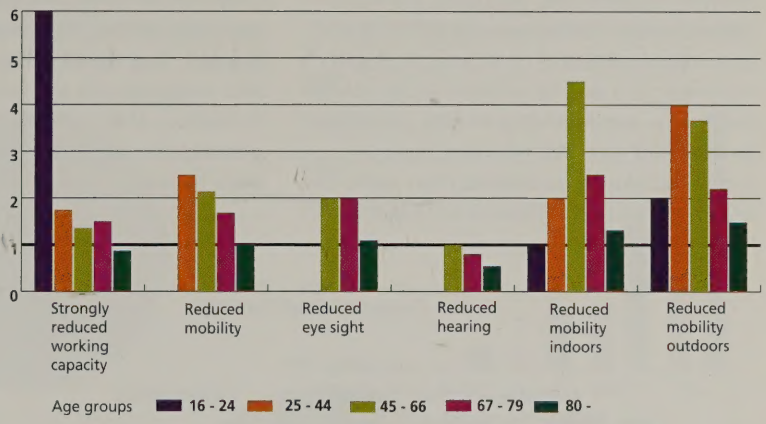
Mean population by age and sex, by percentage, 1992.



Source: Health Statistics in the Nordic Countries 1992, NOMESKO 42;1994

1.1.2 .....but are less healthy.

Long term disability in various catagories. Females/males ratio.

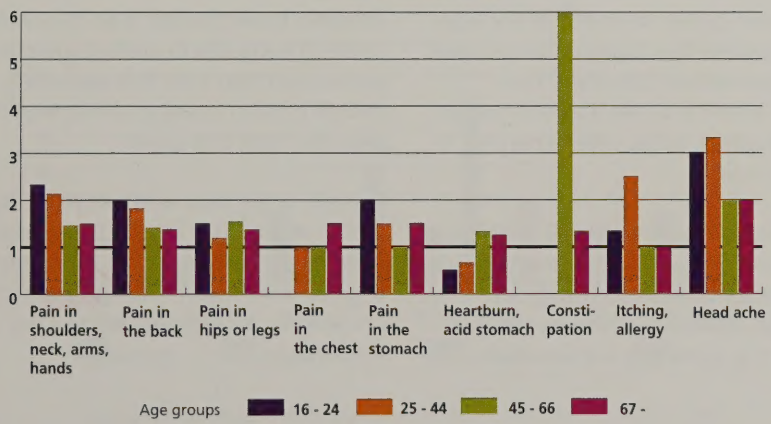


Source: Official Statistics of Norway: Survey of level of living 1991. Oslo: Statistics Norway 1992.

Another picture emerges if we look at indicators for morbidity; practically all these indicators show that women are disadvantaged compared to men. We will here look at some of these indicators. Women score higher than men when asked about **long-term disability.** The following data stem from a survey done in 1991.

Self-reported health is recorded in health surveys performed approximately every 10 years. The next is soone due; the last study is from 1985. It gives some details on specific health problems experienced over a period of two weeks. With very few exceptions, women report more health problems than men.
From these data we see that head ache and musculo-skeletal problems, toghether with problems of digestion, are particularly common among women.

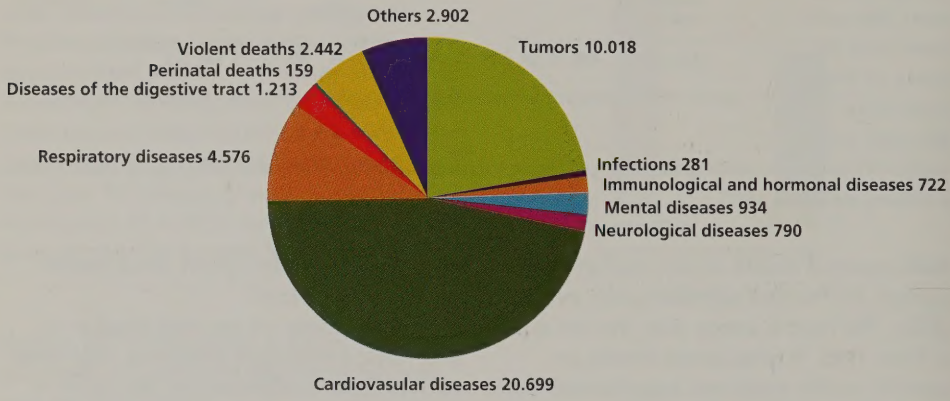
Percentage of women 16 years and over with specific troubles in the survey period. (14 days) Females/males ratio



Source: Official Statistics of Norway, Oslo: Statistics Norway 1987. Health Survey 1985.

Women more often than men **seek primary health care**, and they are hospitalized more. Some, but not all, of the over-representation of women is due to reproduction and to women living longer than men, experiencing health problems in their old age. Women also have a higher **intake of medicines** than men. The bias is particularly great with respect to tranquillizers. These are available on prescription only, and their use therefore depends on the judgement of a doctor. Overall, two thirds of benzodiazepams and sleeping pills are taken by women*. Painkillers that can be bought without a prescription are also used more by women than by men.

Causes of death in 1992



Source: Causes of Death 1992. Statistics Norway 1994

1.2 Causes of death

The reported causes of death in Norway reflect a pattern that Norway shares with other industrialized countries. The dominant killers are tumours and cardiovascular diseases, while infections play a very minor role.

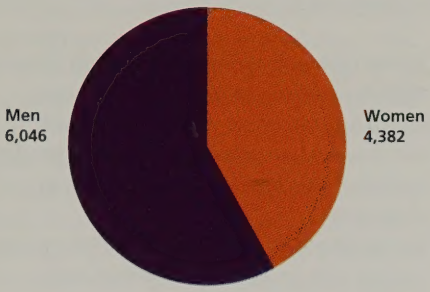
Cardiovascular diseases are the main cause of death in Norway. A sub-group of this is ischemic heart disease. In this group, there are marked differences between women and men. It is generally known that ischemic heart disease is an important cause of early death among men, but it is less known that over the age of 75, an overall greater number of women than men die from this cause.

Cancers strike men and women differently, and a main reason is the high incidence of cancer of the reproductive organs. If we look at malignancies that are specific for women, we see the following:

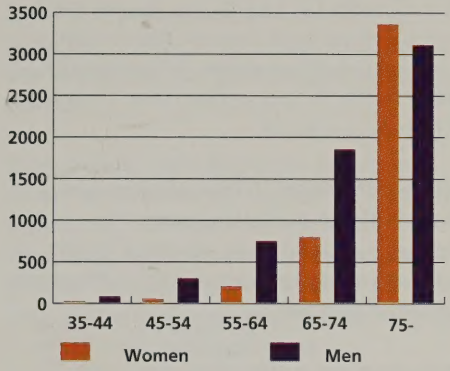
** Bjerke, E. et al: Feed-back reduces the prescribing of anxiolytics. Tidsskr Nor Lægefor 1991;111:2246-8*

Ischemic heart disease as main cause of death in 1992

Total number of deaths for women and men



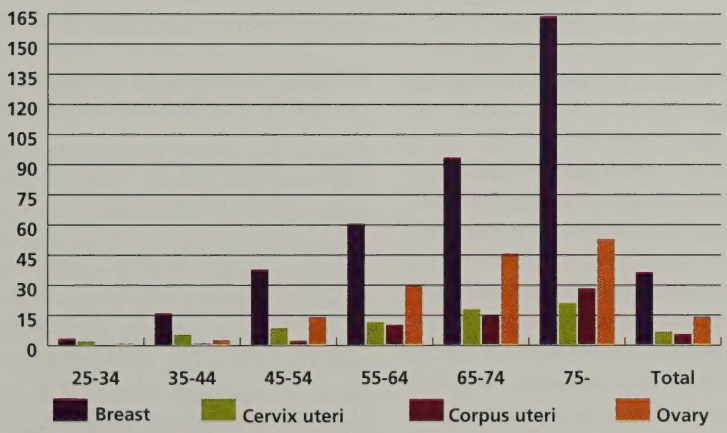
Number of deaths according to age and sex



Source: Causes of Death 1992. Statistics Norway 1994

Breast cancer is still the most common type of cancer in women. But lung cancer is on the increase, and is expected to become the leading cause of death from cancer in a few years.

Mortality rates among selected female related malignancies. Mortality per 100 000



Source: Official Statistics of Norway: Causes of deatht 1992. Statistics Norway, 1994.

1.3 What do the indicators tell, and what do they not tell?

If we use data on mortality and morbidity as indicators for health, we do not get a consistent picture: women live longer than men, but are sicker. Is their health, then, better or worse then men's? Are the differences «real»?

While differences in mortality in some cases indicate overall inequity, e.g. between social classes, we need other instruments to understand the differences between genders.

Indicators are crude measures; they cannot explain the complex reality that people live in and why they make their choices. We still lack proper indicators for health - for the strengths and capabilities people have to cope, the creativity they use to stay well and tackle the small and big problems they face, and their solidarity with others which is so important in mobilizing human resources. Women seek professional help to a greater extent than men. Does this reflect that women's expectations are not met, and that they are trying to put things right? Or are men the ones in trouble, who, by neglecting their health and failing to seek help for symptoms of disease, die prematurely? We can only guess.

It is important to have a gender perspective on how indicators for morbidity and mortality are selected and interpreted. Such indicators have a lot of impact on public opinion: on what is important and what is not, on allocation of resources and on priorities in research, to name a few.

1.4 How and why do diseases affect women and men differently?

For biological, social and cultural reasons, women's and men's disease patterns differ. Here are some examples:

- Some diseases strike women and men at **different ages.** As mentioned above, quite a number of women die from cardiovascular diseases, but they tend to contract the disease at an older age than men.
- Some diseases or conditions, like cervical cancer and pregnancies, **affect only women.**
- Some diseases are **more prevalent** in women than in men. Examples are thyroid gland disorder, rheumatic diseases, musculo-skeletal diseases and anaemia.
- Some diseases or conditions, like osteoporosis and some rheumatic diseases, are **more serious** among women or among groups of women.
- The **risk factors** of some diseases or conditions, e.g. some occupational hazards, **are different.**
- For some diseases, **interventions,** like operation technics for intestinal cancer, **are different** for women and men.

1.5 The hierarchy of diseases - a subtle discrimination of women?

Medical personnel do not only examine and treat sick people, they are also responsible for administering important social benefits. Being defined as sick implies freedom from a number of obligations and getting into a new role in the society. Health workers are instrumental in confirming the role of the sick person, which is important for social recognition, patients' self-esteem, credibility, and for monetary compensation. Some ailments

are more prestigious than others, and this may influence the rights and privileges of the sick person in subtle ways.

Some studies have been made on how the different diseases are ranked on a scale according to how they are valued*. The differences in prestige have shown to be substantial. Diseases of vital organs, and with clear-cut symptoms, carry weight and give respect. On the other extreme, diffuse symptoms in various parts of the body, without a known cause, carry the lowest prestige. Fibrositis and depressive neuroses rank lowest on the scale. As these diagnoses are more frequent in women than in men, women may run the risk of getting less recognition, receiving poorer quality service and less monetary compensation.

1.6 A society based on solidarity and welfare - with a gender bias?

1.6.1 Health financing and the public health system

The Norwegian government spends 7.5 to 8 per cent of the Gross Domestic Product on health care. Everyone living in the country is covered by the national medical insurance system. Compared to many other countries, the system gives good value for money.

Staying in a hospital for any cause is free of charge for the sick, but for outpatient treatment the patient has to pay a small share. Treatment for some conditions and ailments is, however, free; antenatal care and treatment for sexually transmitted diseases or tuberculosis are among these.

Both publicly and privately employed medical practitioners receive funds from the public system. In addition, there is a small number of practitioners and clinics in the bigger cities that operate on a totally private basis where the whole amount is paid by the patient. But by and large the private system has never posed any substantial competition to the public system.

From time to time there is a debate on what the public health system should and should not cover, and on the kinds of medical conditions that should be given priority. Discussions on the use of technology, particularly reproductive technology, flare up every now and then.

We have no reason to believe that there is any major gender imbalance in the allocation of resources for health services. But there is a need for better monitoring instruments and more qualitative information.

1.6.2 Social security

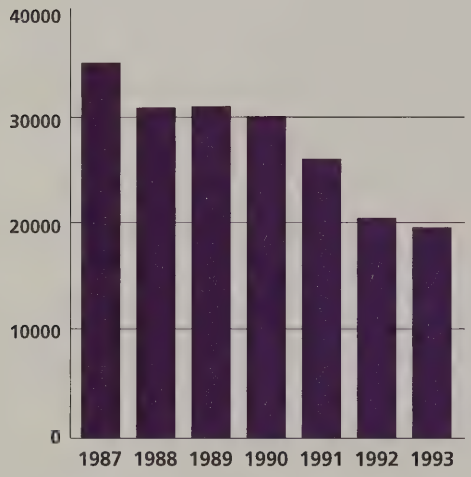
In principle, every person in the country has the right to subsistence in cases where they cannot fend for themselves: in cases of disease, disability, unemployment or for certain social reasons.

The system for judging who has the right to subsistence must necessarily be complicated. On the one hand, nobody should be without subsistence due to sickness or disability. On the other hand, there must be mechanisms to exclude the ones who are «not worthy» of public support. For example, one of the prerequisites for getting paid sick leave is to follow the doctor's advice on treatment, and disability pension can only be granted on proper medical grounds, implying that a recognized diagnosis is required.

**Album, D.: The prestige of diseases and medical specialities. Tidsskr Nor Lægeforen nr. 17, 1991;111:2127-33*

The yearly increase in number of persons on disability pension became worrisomly high in mid 1980s. Concern about the increase has been twofold: fear of social marginalization, and the increase in public spending. This led to stricter criteria for granting disability pension. There has been a deliberate effort to reduce the number of men on disability pension due to drug abuse, alcoholism and social problems, and of middle-aged women with musculo-skeletal disorders and

Number of persons granted disability pension, in the population, since 1984



Source: Yearbook of Statistics on Social Security. The National Insurance Administration 1994.

mental problems. The overall number of persons granted disability pension peaked in 1987 with around 35 000, from then on is has declined.

1.6.3 Gender bias in social security?

We still have too little information to conclude whether women are receiving fewer social benefits when they are sick than men. Comparison is difficult, but it is certainly an area that merits closer investigation.

There is a gender bias in the number of applications for disability pension that are turned down. In 1992, the overall rejection percentage was 22 for women and 14 for men*. Even among persons having the same diagnoses, women experienced a higher frequency of rejections than men. The rejection rate was particularly high among younger women with fibrositis and myalgia: 72 per cent of women aged 16-34 were turned down. Among women aged 60-67, 27 per cent of applications were rejected.* Fibrositis still lacks criteria that are generally agreed, and is one of the so-called «ill-defined conditions». The majority of the sufferers are women.

Reports show that 30 per cent of persons whose application was not accepted, have to depend financially on their family members. This goes against the principle of taking care of members of society that cannot earn their own income due to disease.

1.7 Women's status and workload

Compared to many other countries, women in Norway have gained a relatively high social status. And yet there are weaknesses, and challenges remain to improve the present conditions and make women more equal with men.

1.7.1 Formal rights

The strong position of women in Norway today has come about step by step and with a lot of struggle. Some highlights in the improvement of women's rights are shown overleaf.

** Bruusgaard, D.: Fibromylgi og trygd. In: Abusdal, U.G. & Natvig (eds.): Fibromyalgi? TANO, Oslo 1995*

Some milestones in the history of Norwegian women.

1858: The telephone and telegraph administration was opened to women, the first of the public services to do so.

1884: Women were given the right to study at university and take the final exam at all faculties. After completing the examination women could open practices as physicians and dentists, but in other respects did not have access to public offices for which they were qualified.

The Women's Rights Association was formed the same year.

1911: The first women took a seat in the parliament.

1913: All women received the right to vote in the general election.

1915: A new act gave children equal rights, irrespective of whether the parents were married or not.

1924: The first Health Centre for mothers was established.

1936: The Worker Protection Act gave mothers the right to leave of absence from work six weeks before and six weeks after giving birth, and stipulated that they could demand their jobs back after taking this leave.

1945: The first women was appointed to the Cabinet.

1961:
The first women vicar was ordained.

1964: Decriminalization of abortion.

1966: The National Insurance Act. Better rights for unmarried mothers.

1972: The Equal Status Council is established.

1975: The Kindergarten Act. The municipalities are required to prepare a programme for the establishment and development of kindergartens.

1977: A Secretariat for Research on Women was established.

1978: The Act concerning termination of pregnancy allows women to make the final decision concerning termination of pregnancy.

1979: The Equal Status Act enters into force.

1993: Paid parental leave is prolonged up to 42 weeks. A «father's quota» of four weeks is introduced; this is exclusively for the father and is forfeited if the father does not utilize his right.

1993: The first woman bishop was ordained.

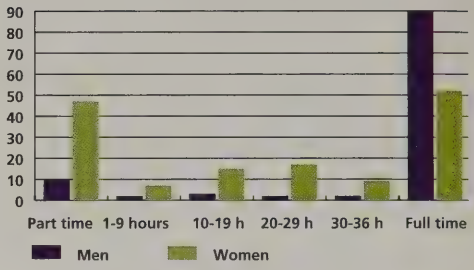
1993: A new provision was added to the Municipal Act indicating procedures to ensure 40 per cent of each sex on municipal committees, boards, etc.

Source: The Gender Equality Council, modified.

1.7.2 Women's participation in society

Participation in paid work:
There has been a massive change in women's participation in employed work over the past few decades. In 1965, approximately nine out of 10 mothers with small children did not have paid employment. Today, the situation is almost reverse; close to eight out of 10 mothers with small children work outside the home. More and more women now work full time, even during the years when their children are small. The change has not only made women more economically independent, but has also changed the way in which family life is structured.

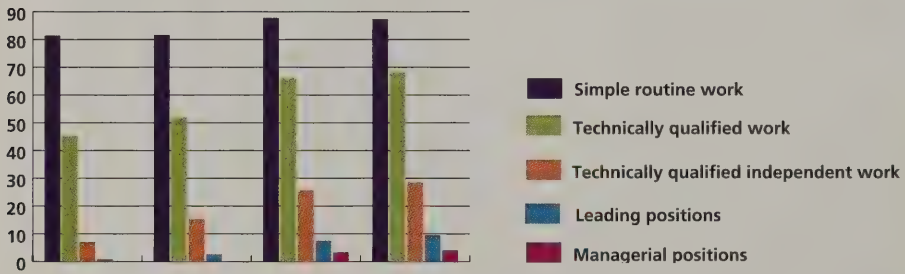
Working hours for women and men 1993. Percentages.



Source: Minifacts on Equal Status. Gender Equality Council 1995.

Women work part time to a great extent, while most men have a full-time job.

Percent of women in business

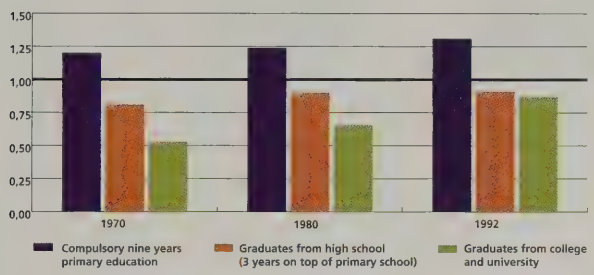


Source: Annual Report. Gender Equality Council 1992

Women still have a long way to become equal partners in business, an particularly in competing with men in top-level jobs. The discrepancy is particularly great in the private sector, and progress has been slow, except in the category of «technically qualified independent work».

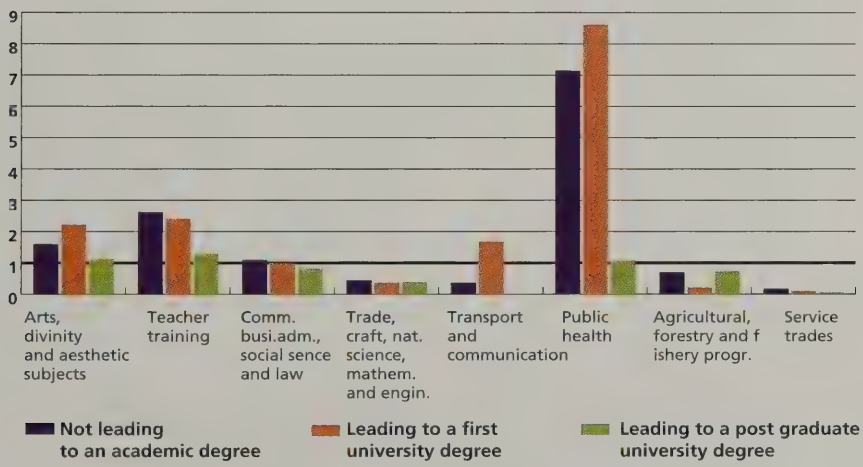
Education:
A dramatic change in girls' education started somewhat later than the entrance into the work force. An enormous growth in both secondary and higher education started around 1975, and this is largely due to the rising number of women seeking education. Today, between 52 to 55 per cent of students enrolled at universities and colleges are women. The ratio of females to males with a completed college degree has increased substantially.

Highest completed education of persons 16 years and above, 1970 - 1992. Females/males ratio.



Source: Official Statistics of Norway: Statistical Yearbook 1994. Oslo: Statistics Norway 1994.

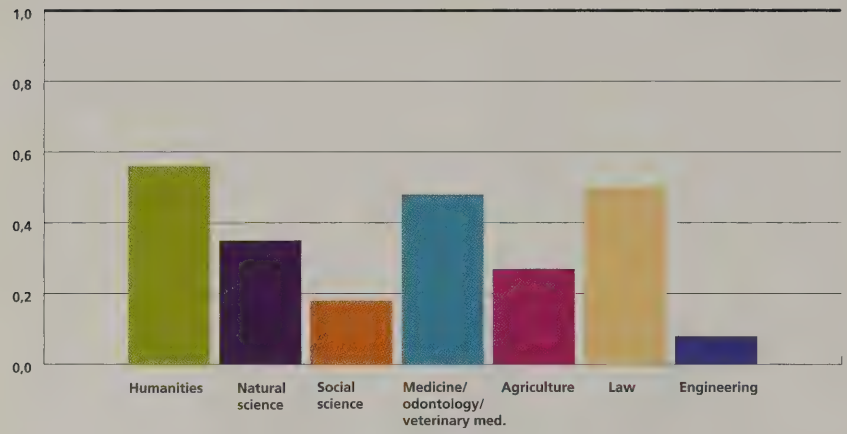
Females/males ratio of students who completed an educational level and field of study. 1991/1992.



Source: Official Statistics of Norway: Statistical Yearbook 1994. Statistics Norway 1994.

There is a clear gender division with respect to choice of education, and the health sector is dominated by women.

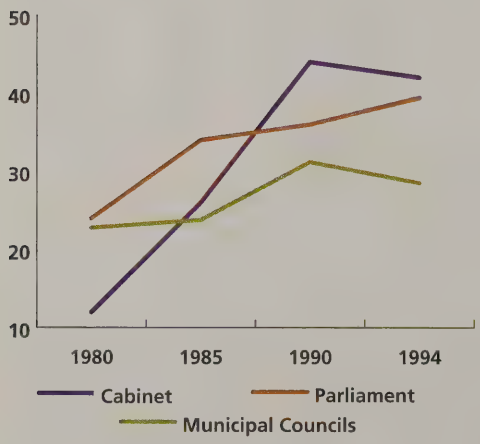
Women with doctors degree per 31.12.93.
Females/males ratio.



Source: Official Statistics of Norway: Statistical Yearbook 1994. Oslo: Statistics Norway 1994.

Among doctorates there are still few women, particularly in the traditionally male-dominated disciplines.

Representation in percentage of women in the Cabinet, the Parliament and municipal councils from 1980 to 1994.



Politics:

There has been a tremendous increase in women's participation in political life. Norway's Prime Minister, Dr. Gro Harlem Brundtland, is known world-wide. But there is a large number of other powerful women in prominent positions in political parties.

The high participation of women in politics has become possible only by employing special measures. The system of quotas has been the most important one. Under this system either gender must be represented in committees and councils with a minimum percentage. This has the effect of involving women in all sectors of the society, including the typically male-dominated areas like economics, agriculture and defence. It has also helped to involve men in typically

female areas, like education and health. When quotas were introduced in 1970s by the left-wing parties, the system was highly controversial. The opponents argued that it might compromise quality. Presently most of the political parties have accepted quotas as part of a democratic ideology where interests are to be voiced.

Women's organizations:

In earlier days, charity organizations worked to fulfil people's basic needs, like health and welfare. The majority of members of such organizations were women. But with the growing realization of the Welfare State, the public sector has taken over many of these tasks.

Some organizations have worked with specific health problems like tuberculosis at the time that disease was dreaded for the toll it took particularly on young lives. Other organizations have been pioneers in the education of nurses and providing health care for special groups of patients.

Today, there are special organizations for promoting the interests of other patient groups, like people with fibrositis.

The increase in women's participation and power sharing in the society is unthinkable without a strong base of activists in organizations, articulating and lobbying for women's rights. The organizations have become pressure groups for certain issues and rights, and often organize campaigns for specific political aims, like legislation to combat pornography.

Women's association in Drivdalen, founded 1902

Demonstra

1.7.3 The private sphere: sharing work and taking care of children

Women's increased participation in societal life creates new challenges in organizing private lives. In an equal society like Norway, domestic servants are practically non-existent. Even with the number of household appliances that people normally have, there are tasks that cannot be mechanized. And children need love, care - and work.

There has been a change in mentality as to what is women's work and what is men's. Forty years ago, children learned to read with books containing phrase like:

MOTHER IS SEWING.
FATHER IS READING.

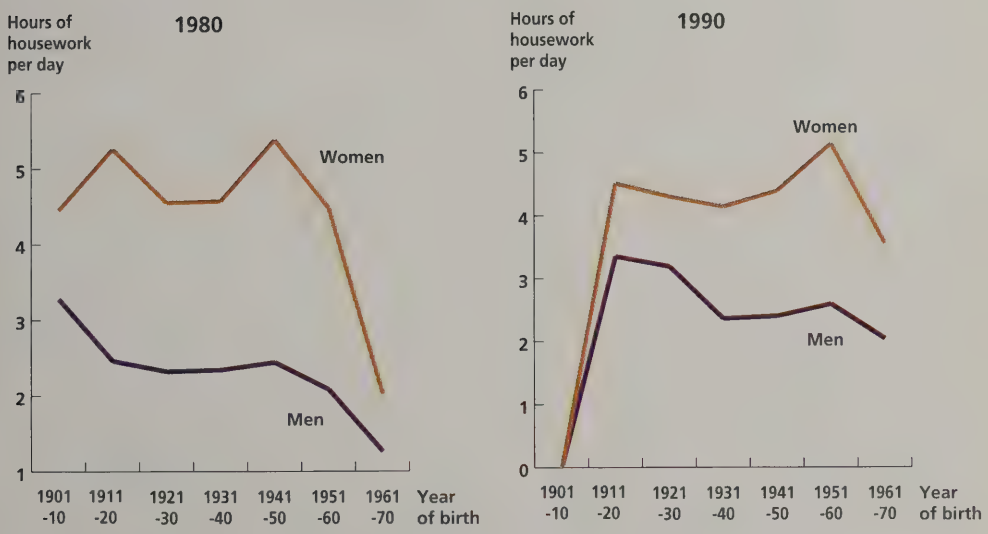
Presenting stereotype gender views like this in schoolbooks is banned today. Neither do they reflect the prevailing values.

Still, women do considerably more housework than men, but surveys have shown that the gap is diminishing slowly among younger age groups.

Childcare is an area that becomes a shared responsibility of families and society when many women are employed outside the home. The creation of more day nurseries and kindergartens was for many years a main issue for women's organizations. Now the number of creches and kindergartens has increased, and maternity leave has been prolonged. But many families still have difficulties in finding good, affordable childcare while the parents are at work.

Each parent has the right to 10 days of paid leave annually when caring for a sick child at home, and single parents have the right to twenty days annually. Recently the age limit of the child was raised from 10 to 12 years.

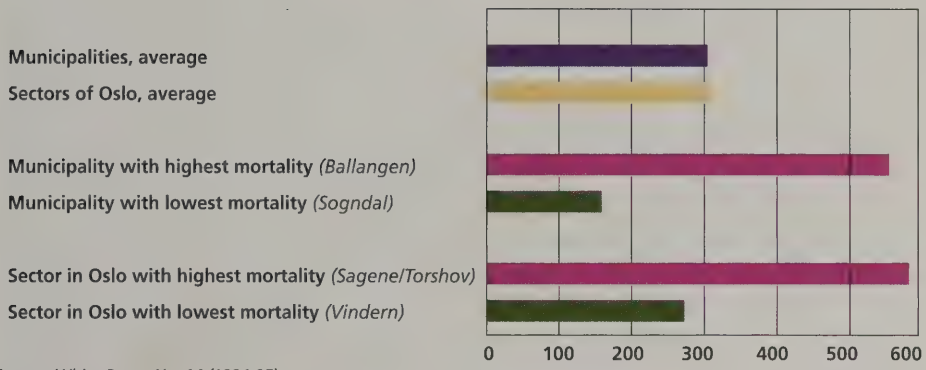
Daily housework , in hours, for women and men of different age groups.



Source: Level of living in Norway. Norges Offentlige Utredninger NOU 1993: 17. Oslo 1993.

Over the years, there have been discussions on whether a kindergarten can give children sufficient care, and conservative forces tend to emphasise the need for mothers to stay with their little ones. But recent studies have shown that children who stay in kindergartens do as well emotionally and intellectually, if not better than children who are with their mothers all day long.

Mortality per 100,000 inhabitants aged 20-64, adjusted for age and sex. Average, from 1987-1992



Source: White Paper No. 14 (1994-95)

1.8 Inequities in an equal society

Norway has traditionally been regarded as ethnically and socially homogeneous. Solidarity and equity have been the pillars on which the society has been built, and this has in particular been the basis for the policy on health and social welfare.

Social inequalities are smaller in Norway than in many other countries. But they do exist, despite a tendency to ignore such differences. It was a surprise to many when it was shown that mortality is as much as 2.7 times higher in the least affluent parts of the capital compared to the most affluent part. There are also substantial differences between the various counties. It is not known if social differences affect women's and men's health in different ways.

International literature often claim that women belonging to ethnic minorities suffer the triple disadvantage of race, class and gender. Norway has also got its ethnic minorities. The Sami people, who live primarily in the northern part of the country, are the indigenous people of Norway. Traditionally they were nomads living from raising reindeer, but now largely live permanently in houses. For a long time the official policy was assimilation, and the Sami culture and language were neglected. Now the Sami people have gained more political power and self-determination. Knowledge about their health patterns, including the health

All have profitted from men taking more care of children.

Sami women

of women, is largely non-existing, but the need for culturally sensitive health care has been recognised. It is also seen as important to make education in the health professions attractive to young Sami girls and boys. A plan for improving health services for the Sami people has been adopted, and overcoming language barriers is one central element in this plan.

In the 1970s, Norway experienced the start of an influx of immigrants and refugees that had not been seen in its history before. Compared to many other European countries, Norway became the host country of immigrants at a late stage, and comparatively few have settled here. Approximately 165,000 foreign citizens now live in the country. There are few studies on the health status of immigrants, but there are indications of increased mortality for both children and adults. Some health problems are specific among immigrants and refugees, or more common among them. Genetic disorders, communicable diseases, mental problems due to discrimination and xenophobia, and health problems due to traumatization and torture in their country of origin are among these. Early on it was recognized that especially immigrant women may have difficulties in having their health care needs met, and special measures must be implemented for them to have their rights to health care fulfilled. Translators are necessary, and cultural sensitivity among health staff is also required.

2. LESSONS AND CHALLENGES: SELECTED AREAS

2.1 Sexual and reproductive health and rights

2.1.1 Major changes have taken place, but reproductive choices will always remain relative

Over the past few decades, women in Norway have experienced a revolution with regard to their opportunities to make reproductive choices. The introduction of reproductive health technology, advancement of women and increased knowledge of sexual matters have transformed the lives of today's women to the extent that our grandmothers could not have imagined. As habits and practices rapidly change, the value system is also questioned and partly redefined.

There are clear limits to the extent to which individuals can make reproductive choices, and reproductive choice will always have to be a relative term. There are many reasons for this. Biological factors determine reproductive capacity, methods of fertility regulation are never totally efficient, and some experience untreatable infertility despite new technology. Sexuality can never be fully planned and controlled, and reproduction can never be the choice of one individual in isolation. While sexuality is an extremely private and sensitive issue, it is at the same time a public matter to a certain extent, and sexual and reproductive behaviour is influenced by public values.

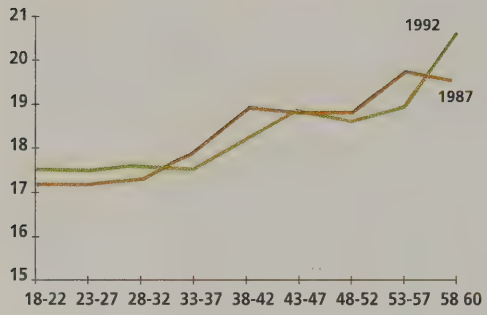
2.1.2 Sexual health and ill-health

Sexual health can be defined as having a sex life that enhances life and personal relations, without fear of unwanted pregnancy or disease. Even if it is defined in a positive way, sexual health is often measured in terms of the absence of negative effects. The positive definition may be more useful for individuals' subjective assessment or for an overall goal than for measuring health in society, since positive indicators for sexual health are difficult to design. We will here present available information from Norway on sexual behaviour and sex education in addition to data on sexually transmitted diseases.

Sexual behaviour

In 1987 and 1992, community-based studies on sexual behaviour were carried out. They were spurred by the need to predict the development of the HIV/AIDS epidemic in the country, and to design preventive actions. The emphasis was put on sexual behaviour rather than on attitudes and values. In the studies, women and men of different age groups were involved, and it is therefore possible to make gender analyses and to see differences between generations and follow trends.

Median age at first intercourse for women, according to age

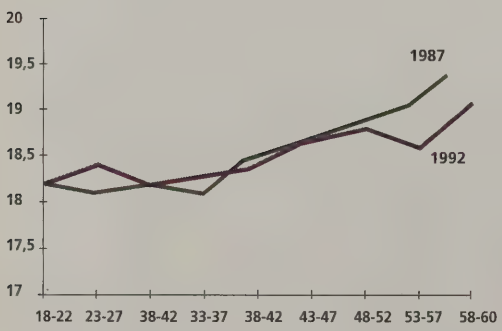


Source: Rapport fra seksualvaneundersøkelsene i 1987 og 1992 (Report from surveys on sexual behaviour in 1987 and 1992). National Institute of Public Health, 1993.

Age at first intercourse

Presently the median age at first intercourse is approximately 17 1/2 years for girls, and one year older for boys (median age implies that 50 per cent of the informants had had their first intercourse at that age). The tendency for girls to start their sexual life earlier than boys has gone on for some decades, according to existing data. There was a drop in the median age at first intercourse between the groups that are now around 60 years of age, and the ones that are now in their 30s. The age at first intercourse decreased by two years over this time. For the last 15 years, the age at first intercourse has remained unchanged.

Median age at first intercourse for men, according to age



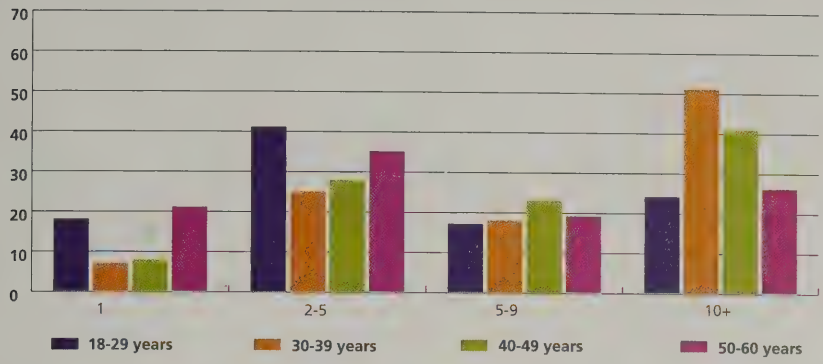
Source: Rapport fra seksualvaneundersøkelsene i 1987 og 1992 (Report from surveys on sexual behaviour in 1987 and 1992). National Institute of Public Health, 1993.

More responsible sexual behaviour after the onset of the AIDS epidemic

A main purpose of the studies on sexual behaviour was to see if people behave more responsibly after the AIDS epidemic has reached the country, and awareness programmes have been carried out for the public at large, in schools and for special risk groups. Since our purpose here is to look at the health of women, data on responsible sexual behaviour are of particular interest, as women to a larger extent than men suffer from the undesired effects of casual sex. We will therefore present data on the number of sex partners and use of condoms during casual sex.

The study from 1992 gives us a partial answer to the question of how many sexual partners people have through their lives. Men and women who presently live alone were asked how many partners they had ever had. Naturally the older age groups reported the highest number of partners. Women and men reported approximately the same number totally, except that there were considerably more men with many partners, i.e. more than 10.

Number of partners of women presently living alone, by percentage



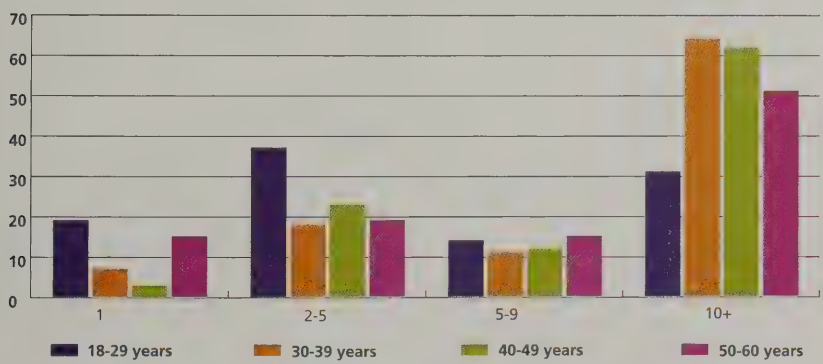
Source: Rapport fra seksualvaneundersøkelsene i 1987 og 1992 (Report from surveys on sexual behaviour in 1987 and 1992). National Institute of Public Health, 1993.

Comparisons between the studies from 1987 and 1992 show that there has been an overall decrease in the number of sexual partners for persons who live alone. There is also a decrease in the number of persons having extramarital affairs in the younger age groups, while among persons above the age of 48, there is an increase in unfaithfulness.

Condom use during casual sex is still low: in the 1992 study only about 20 per cent of people living alone reported using one. This is, however, an increase from an even lower 15 per cent in the 1987 study. There was also an increase in condom use in extramarital affairs, from 11 per cent in 1987 to 15 per cent in 1992.

The studies thus indicate that there has been a change towards more responsible sexual behaviour, but that there is still much room for improvement.

Number of partners of men presently living alone, by percentage

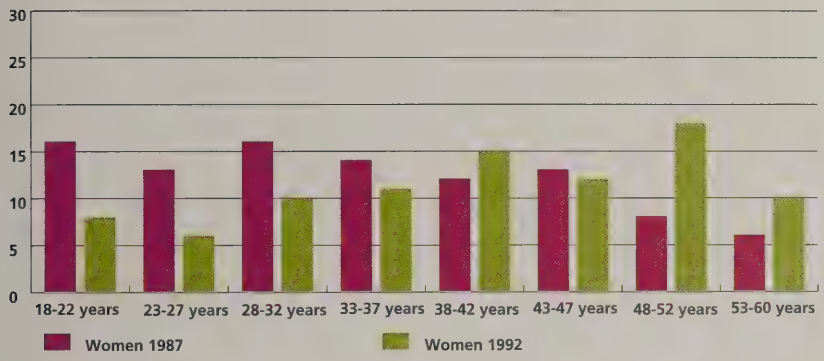


Source: Rapport fra seksualvaneundersøkelsene i 1987 og 1992 (Report from surveys on sexual behaviour in 1987 and 1992). National Institute of Public Health, 1993.

Sex education - a shield against sexual ill health

For a long time Norway shared the Victorian taboos on speaking about sexuality. But at the beginning of this century, the work of demystifying sexuality and promoting openness on sexual matters gradually gained ground, and sex - education was seen as important for promoting sexual health and more fulfilling relationships. The pioneers in promoting women's rights also promoted reproductive choices - for which there was almost only sex education to build on before the contraceptive technologies became available.

Percentage of women reporting infidelity in their present relationship, in the studies of 1987 and 1992



Source: Rapport fra seksualvaneundersøkelsene i 1987 og 1992 (Report from surveys on sexual behaviour in 1987 and 1992). National Institute of Public Health, 1993.

Percentage of men reporting infidelity in their present relationship, in the studies of 1987 and 1992

Source: Rapport fra seksualvaneundersøkelsene i 1987 og 1992 (Report from surveys on sexual behaviour in 1987 and 1992). National Institute of Public Health, 1993.

«Know where to draw the line».
From a campaign for young people

Sex education got an important upswing under the country's late Director General of Health, who served from 1938 to 1972. Dr. Karl Evang was a pioneer in the area. As early as in 1930 he had published a book on how to regulate fertility, and for many years he was the editor of a magazine on sex education. He was way ahead of his time in insisting that knowledge about sexuality was a prerequisite for health and good quality of life at a time when many still felt that sexuality had only marginal links to health, or felt that what he was doing was indecent and posed a threat to public morals.

When Norway introduced abortion on demand in 1978, it was feared that abortion figures would rise. It turned out, however, that these fears were unfounded. Substantial resources were allocated to prevent unwanted pregnancies. Innovative sex education programmes were implemented, building on the tradition of openness in sexual matters, with support from top health officials. At this time, the stressing of positive messages about sexuality became more prominent. Young people should not be deterred from having sex, the aim was rather that they should be enabled and empowered to make their own decision on if and under what circumstances they should have sex.

When the AIDS epidemic brought new threats to reproductive health in the 1980s, there was once again a need for enhanced sex education. Sex education programmes for the general public as well as for prioritized risk groups, like homosexual men and commercial sex workers, have been carried out. Research has confirmed what has been found in other countries, namely that increased awareness does not lead to increased sexual activity. While an increase in knowledge and awareness over these years has been observed, there has been an overall decrease in casual sex and in sexually transmitted diseases. Moreover, the number of persons with HIV infections is far below what was expected and feared, and the previously seen decrease in the sexual debut age has stagnated.

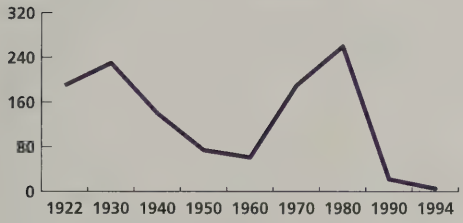
Central and local government structures have been leading forces in promoting openness on sexual matters, but a number of non-governmental organizations have also been active. One example is an association of medical students who organize sex education programmes in schools. Their status as «almost doctors» gives them authority and credibility, and yet they are still young and are perceived as peers. The association has also worked with ethnic minorities with great success. They have overcome many stereotypes, like the notion that it is impossible to talk to Muslim girls about sexuality. The medical students have shown that if the education is done with sensitivity and respect, there is acceptance across cultural boundaries.

There are still many challenges with respect to sex education, particularly for young people. This pertains to methodology, content and coverage. While sex education in the schools has improved recently, it is taught as part of various subjects and is still not compulsory.

Sexually transmitted diseases, including HIV and AIDS

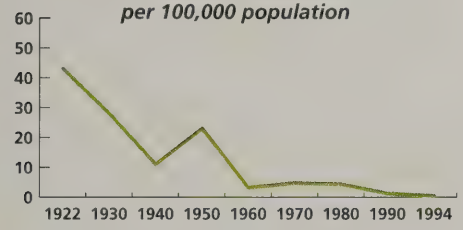
There has been a steady decrease in reported cases of conventional sexually transmitted diseases over the last years. A substantial decrease has been seen for gonorrhoea, syphilis and hepatitis B. Gender specific data have only been collected for the last couple of years, and are not presented here.

Number of reported cases of gonorrhoea per 100,000 population



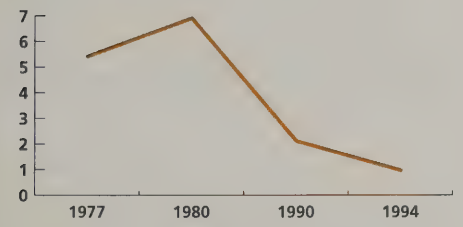
Source: National Institute of Public Health

Number of reported cases of syphilis per 100,000 population



Source: National Institute of Public Health

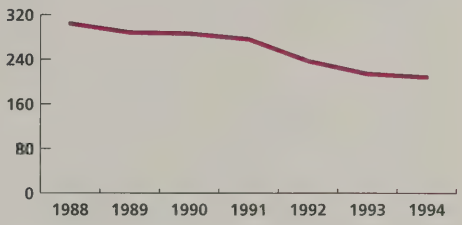
Number of reported cases of hepatitis B. per 100,000 population



Source: National Institute of Public Health

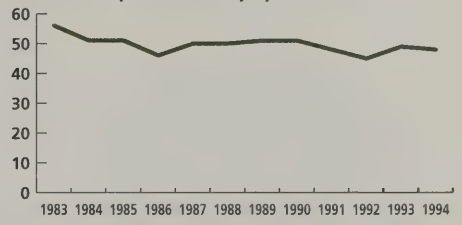
Chlamydial infections and genital herpes have only been reported for a few years, and for these two categories the picture is different, with only slight changes.

Number of reported cases of chlamydial infections per 100,000 population



Source: National Institute of Public Health

Number of reported cases of genital herpes per 100,000 population



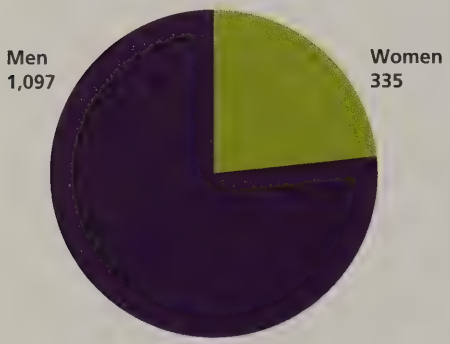
Source: National Institute of Public Health

Chlamydial infection is now the most prevalent sexually transmitted disease in the country. Around 9,000 cases have been confirmed annually. This works out to a ratio of 2.1 cases per 1,000 inhabitants*. While there is an increase in the reported cases among men, the vast majority of the detected cases are still women. With the close link between chlamydia infection and infertility, it appears that chlamydia today is one of the most important threats to reproductive health in women.

** Communicable Disease Report, National Institute of Public Health 1995; 25:5.*

The present prevalence of HIV is much lower than what was feared some years ago. Still, homosexual activity among men accounts for the greatest number of cases, and drug use comes second. Heterosexual activity accounts for only about 20 per cent of all known cases, and most of these are imported. The risk of heterosexual transmission of domestic origin is therefore still very small: only three persons were reported to have caught HIV infection in that manner in 1994. Of course there are a number of undetected cases in all categories, but even among commercial sex workers the existing cases of HIV infection stem from intravenous drug use rather than from sexual contacts.

Reported HIV infections, cumulative data, at 31 December 1994.



Source: Communicable Disease Report, National Institute of Public Health 1995; 25:3.

HIV testing is voluntary, and anonymous testing is accepted. The civil rights of HIV-positive persons are protected, and is one of the efforts to avoid stigmatization.

It is of course difficult to know for sure why the epidemic has not become as widespread as predicted. It is presumed that the intense information programmes for the general public that were launched during the late '80s have been instrumental.

The very low HIV prevalence among heterosexuals is of particular importance for women's health. The data that we now have about sexual behaviour, tell us that high-risk behaviour is rare. Sexually transmitted diseases that facilitate the transmission of the virus are also rare, particularly syphilis and other infections involving open sores.

The generally high status of women is regarded to be of central importance. Women do not have to rely economically on men for their subsistence, and are relatively empowered. This implies that they have negotiating power in deciding when sex is going to take place, and can refuse unsafe sex.

2.1.3 Reproductive choices, reproductive health and rights

Fertility

When contraceptives became available, the process of deciding when and if to have children changed. Other factors underlying the choices of individuals, also underwent changes. As in other countries, the most prominent ones are the rise in the educational level of females and increase in formal employment of women.

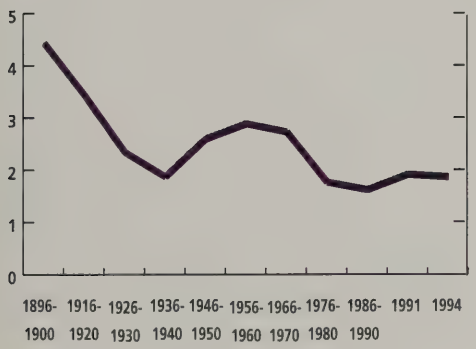
Number of children

At the turn of the century, the total fertility rate was above four children. During the depression in the 1930s and the Second World War fertility declined. This cannot be explained by use of contraceptive technology, as it was not available at that time. After the war, the total fertility rate rose again, reaching almost three. A new decline started around 1970, and can be seen in connection with the changing roles of women. The current total fertility rate, 1.9, is just below the replacement rate.

Age at birth of first child

Women in Norway are older today when they give birth to their first child than what was the case some decades ago. Among women who were born in 1933-50, 50 per cent were mothers at the age of 23, and at the age of 27, three out of four had children*. But women who are born in the mid-1950s and later have made other choices. Of women born in 1965 only 32 per cent were mothers at 23 years of age.

Total fertility rate since 1900



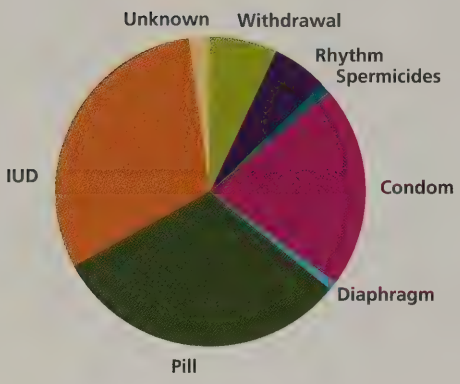
Regulation of fertility

With the increase in women's age when having their first child, and a steady age of about 17 1/2 years for girls at their first intercourse, the use of contraception among young people becomes an important issue for reproductive choices. A study from 1988 showed that three out of four were using contraception during their first intercourse, and more than 50 per cent of the total were using condoms**. During the years in which women are most fertile, use of contraceptive pills and intrauterine devices (IUDs) dominate as contraceptive methods, condoms being number three. IUDs have been popular in Norway for many years, and compared to other developed countries, use has been high during the last 25 years. The diaphragm has been used for decades by a small minority; only 1 per cent use this method. Among women approaching menopause, sterilization and intrauterine devices (IUDs) are the most popular methods. Women with higher education use contraception more frequently at a young age and they have their children later in life. For women over 33 years of age, the prevalence of contraception is independent of education level.

* *Blom, S., T. Novack & L. Østby: Giftermål og barn - bedre sent enn aldri? (Marriage and children - better late than ever?) Statistics Norway.*

** *Træen, B. (ed.): Ungdomsseksualitet i AIDS-tider. (Adolescents' sexuality). National Institute of Public Health 1990.*

Percentage of women having used the different methods of contraception during the last 4 weeks.



Source: see footnote*.

Unwanted pregnancies are no longer the nightmare they were when abortions were illegal and unsafe. One in five pregnancies end in an induced abortion: there are about 60,000 deliveries and 15,000 induced abortions, plus an unknown number of spontaneous abortions. Abortion was decriminalized in 1964; before that time the woman could, at least theoretically, be imprisoned for three years for having an illegal abortion. Presently a woman can have a legal abortion on demand during the first 12 weeks of her pregnancy. Induced abortions are carried out in hospitals, most often on an out-patient basis, and with very few complications. The introduction of abortion on demand has not influenced the number of abortions carried out, but did away with clandestine abortions. So far there have been few serious attempts to reverse the present abortion act, but induced abortion is an issue in the public debate.

Infertility

Ten per cent of women never give birth*. While some voluntarily abstain from having children, 4 per cent are childless against their will. The present sexual and reproductive pattern imply that many women are exposed to sexuality during an increasing number of years before their first childbirth. During these years, they may be exposed to sexually transmitted diseases that may hamper their ability to conceive later. It is still unclear what this may imply in terms of overall fertility.

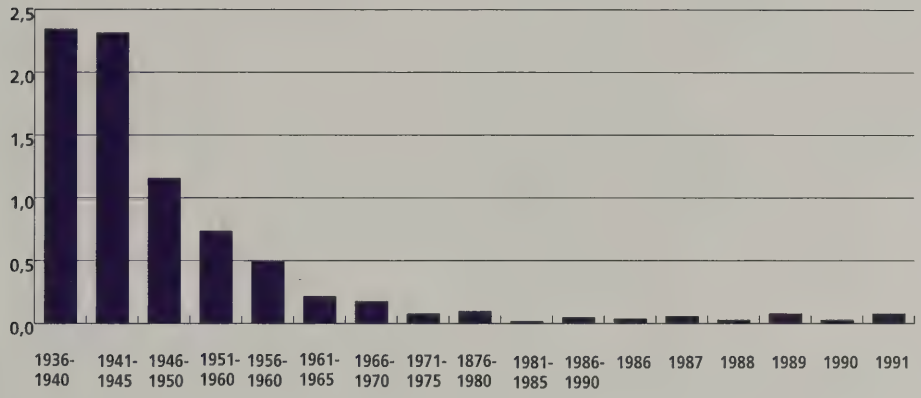
Maternal health

Maternal mortality is a crude indicator for maternal health, but for the sake of comparison with other countries, we present the figures since 1941 here.

It appears that around 50 years ago, deliveries were still risky. Induced abortions were illegal except in extraordinary cases. Our country thus had many of the same characteristics as developing countries have today. Today a maternal death is extremely rare. There were many reasons for the improvement in the survival of pregnant, aborting and delivering women. Besides a general improvement in public health, advances in maternal care have led to this change. In a scarcely populated country like Norway it was of great importance to institutionalize deliveries, providing access to medical interventions when necessary.

* *Blom, S., T. Novack & L. Østby: Giftermål og barn - bedre sent enn aldri? (Marriage and children - better late than ever?) Statistics Norway.*

Maternal mortality rates per 100 000 births



Source: Official Statistics of Norway: Health Statistics 1991. Statistics Norway 1993.

Sugical intervention in reproductive health care

The introduction of more advanced technology, changing medical practices and enhanced expectations of clients, carry the danger of over-medicalization. If we look at the industrialized countries as a whole, reproductive health care seems to be particularly prone to over-medicalization. It is therefore of interest that in Norway the incidence of cesarean section is relatively low. In 1992, an average of 12.5 per cent of all deliveries were performed by cesarean section, and it is believed that this reflects the need seen from a biomedical point of view. But if we compare different parts of the country, some differences appear. The highest incidence was in Oslo, with approximately 15 per cent, while the lowest, in the county of Rogaland, the percentage was only 10 per cent *. While some of the differences between the counties can be attributed to centralization of complicated deliveries, this can only explain part of the difference.

Operations other than cesarean section also differ in incidence between regions nationwide, and such operations are not referred from one county to another. Frequency of hysterectomies varies by factor of 2, from 120 per 100,000 inhabitants in the county with the rarest incidence *(Sogn & Fjordane)*, to 236 per 100,000 inhabitants in the county where the operation is performed most frequently *(Buskerud)*. Similar differences are found with respect to mastectomies, with an astonishing variation from 35 cases per 100,000 inhabitants to 91 cases per 100,000 inhabitants in Buskerud County.**

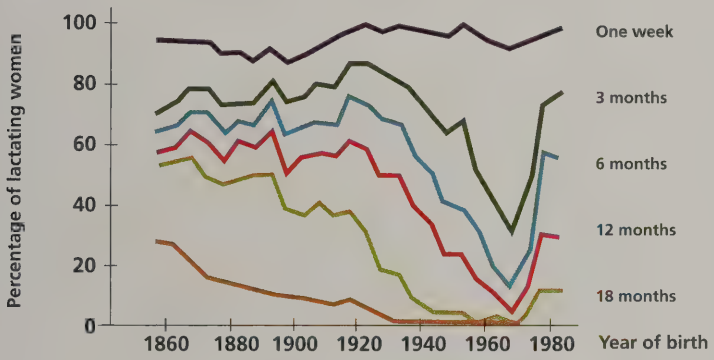
** Medical Birth Registry of Norway, Annual Report 1992.*

*** Sykehus 1991 (Aggregated Data for Hospitals, 1991). SINTEF-NIS (the Foundation for Scientific and Industrial Research - Norwegian Institute of Hospital Research.*

Breastfeeding

Norway is reported to be the industrialized country with the highest prevalence of breastfeeding. In fact, between 98 and 99 per cent of mothers leave the maternity ward breastfeeding, and 75 per cent still do so when the baby is three months of age. There are many remarkable features in the history of breastfeeding in Norway. The link between breastfeeding and chances for survival was recognized before the turn of the century, and breastfeeding was promoted to improve child survival. At that time, breastfeeding was more common among the lower than the upper social classes. Like many other countries, the prevalence of breastfeeding in Norway started declining in the 1940s, first slowly and then more rapidly. Remarkably there was little reaction from health professionals to this decline.

Distribution of durantions of breast-feeding, 1860-1980, for all children born in subsequent 5-year groups.



Source: Liestål, K, Rosenboerg, M, and Walløe, L (1988): Breast-feeding Practice in Norway 1860-1984. J. Biosoc. Sci. 20: 45-58.

This figure shows the prevalence of breastfeeding for children up to the age of 18 months. As can be seen from the curves, there has always been a high number of mothers who start breastfeeding, but the number who continue has varied. Around 1970, breastfeeding prevalence was at its lowest, but then a sharp increase took place. Prevalence has been steady and high ever since. There are many reasons for this dramatic change. The formation of a lay movement of mother-to-mother support groups was introduced in 1968, and has been of essence. The improvement in the status of women that took place in the wake of the feminist era, may have also contributed. Monitoring of infant formula is another reason. Longer maternity leaves may have also contributed, but it is a striking feature that formally employed mothers have managed to combine breastfeeding and work to an amazing degree.

With today's low level of infant and child mortality, no difference can be observed among children who are breastfed and those who are not. Today, high education of mothers is an important indicator for high breastfeeding prevalence.

Breastfeeding and going for a walk in the forest are customs that are generally cherished in Norway.

Breastfeeding is generally held in high esteem by the population.

Sexual violence - a threat to reproductive health

Despite the improvements in reproductive health and rights, sexual violence still occurs in Norway. There is a power imbalance in personal relationships that makes such violence possible, and many women have difficulties in leaving a violent marriage. Violence does not only influence quality of life and wellbeing, it is also a threat to reproductive health. Miscarriages and low birth weight are more prevalent among women who live in violent relationships*.

A small number of studies now exist on the prevalence of violence in partnerships and marriages, and there are indications that approximately 10 per cent of women have experienced violence in their relationships. We don't have reliable data on incidence of rape by unknown offenders.

Despite the fact that victims of violence have consulted health personnel for ages, violence has only recently been acknowledged as an issue that health staff should learn about and deal with. It is to the credit of activist women's groups that the problem has been brought into the open. Some hospitals give special services to victims of rape and other kinds of sexual violence. But still the bulk of the work with these victims is carried out on a volunteer basis by lay women, and a small number of men who have joined force.

Sexual abuse of children has also been defined as a task for health services.

Conservative estimates indicate that 5 per cent of all children are subject to repeated, serious sexual abuse. The majority are girls, but a small number of boys are also abused.

While some information exists about the prevalence of sexual abuse and there is some experience as to how to deal with it, this work is still in its infancy. It is high time that we get more information about this threat to the sexual and reproductive health of the younger generation. Society at large must furthermore work to prevent such violence, and health services must get fully involved in treatment and rehabilitation.

2.1.4 Principles of reproductive health care: full integration of reproductive health care, with extra efforts for special groups

Norway is in the fortunate situation of having a long tradition for integrated reproductive health care. Under the Municipal Health Act of 1982, local governments are obliged to offer reproductive health care as part of primary health care. Special services for the provision of family planning, ante- and post-natal care together with well-baby clinics are provided free of charge for the users. Many use these clinics, where public health nurses, midwives and medical doctors work together. Others go to a general practitioner, or a gynaecologist, but the latter is mainly for high-risk pregnancies. Most medicines, including contraceptives, have to be paid for by clients.

Delivery care and abortion services are provided free of charge in hospitals. It is the right of every women to have a companion with her during delivery, and most choose to have the baby's father there.

** Schei, B.: Trapped in Painful Love. Tapir, University of Trondheim, 1990*

Adolescence is a time of trial and ambivalence

Natural births have become popular, with medical intervention only when necessary. The birth position of the mother-to-be is according to her own wishes, as long as the midwife can do her work. Professionals and women's groups have collaborated to bring about the changes from earlier years' rule-and-regulation orientation at deliveries and in maternity wards, to today's more homelike atmosphere. The changes have also paved the way for the introduction of the Baby Friendly Hospital Initiative, which is now implemented in many hospitals.

But certain aspects of reproductive health care are especially sensitive, and require special skills. Thus it has proved necessary to have some special services for adolescents. Young people's demand for confidentiality is not always met in regular health care, and not all health workers

relate to the youngsters in a way that creates confidence and rapport. Special services for adolescents exist in all bigger towns, and their number is increasing. The special youth clinics do not only provide health care, their experience is also conveyed to the regular services which can adapt their way of working in order to meet the needs of adolescents in a more appropriate way.

2.2 Occupational health

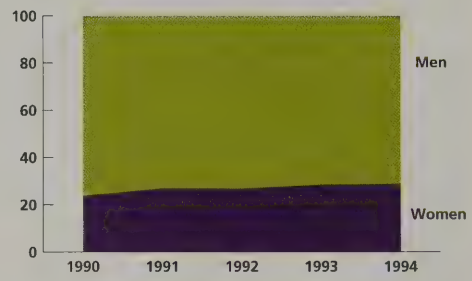
2.2.1 Women's participation in paid work: is it good or bad for her?

The big increase in women being formally employed has had a tremendous impact on society, particularly on women's lives. There are public discussions as to burdens placed on women who work outside the home; indeed many women have little time at their own disposal. But the few studies that exist on the effect on self-reported health and well-being indicate that the health of women benefits from their being employed. This even goes for women who have small children. Paid work seems especially to have a beneficial effect on mental health. But the positive effect on work is not across the board, as there are aspects of health that suffer due to employed work, and there seems to be differences between the social classes.

2.2.2 Occupational injuries and diseases: women are almost invisible

Occupational injuries and diseases are to be reported to a central register. Such cases, however, are underreported, with surveys indicating that only one out of four cases is reported. It is not known whether the underreporting applies to women and men to the same degree. Persons who fall ill when they are employed have the right to paid leave of absence after getting a certificate from a doctor. Cases that are accepted as occupational injuries or diseases have additional benefits. It is therefore important that the system for defining and reporting occupational injuries and diseases is a fair one.

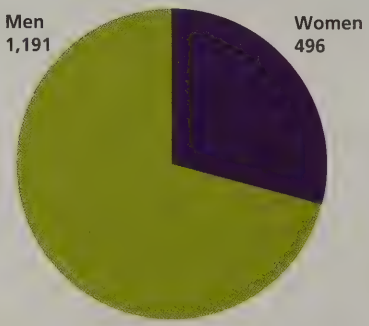
Occupational injuries 1990-1994



Source: Annual Report 1994, Directorate of Labour Inspection.

The statistics on occupational injuries and diseases are strongly gender biased. While women definitely are part of the work force, their appearance in these records is strikingly low.

Occupational diseases, reported for 1994



Source: Annual Report 1994, Directorate of Labour Inspection.

If we compare various types of workplaces, we find that in the social sectors, i.e. health and education, between 40 and 50 per cent of the reported injuries are for women; and in these sectors women make up a majority of the work force. But in all the other sectors, the percentage of the injuries among women is very small compared to men.

Because of underreporting, we cannot draw firm conclusions from these data. Besides there are risk differences between the typical female and the typical male types of work. And yet, we can assume that the health hazards women have at their workplaces are less recognized than men's. This is similar to what many other countries experience. A disease stemming from the work situation does not necessarily qualify for the term «occupational disease», and women seem to be discriminated against in this respect.

2.2.3 Why are women's occupational diseases not recognized?

It is a requirement for the classification of occupational disease that the cause is directly linked to the work, and that outside factors are unlikely to be the reason. The regulations that define occupational diseases specify a series of conditions. Many of these are caused by toxic influences, contamination and other environmental hazards, or job-related allergy. Musculo-skeletal diseases are only accepted as occupational diseases in extraordinary cases, like if they are caused by the use of vibrating instruments. Industrial work, transport and mining are typical examples of men's work. The definition of occupational diseases is tailor-made for these types of labour.

The typical work of women is different in character, and is often physically strenuous (like taking care of sick and elderly or cleaning work), or monotonous (like secretarial work). The link between such working situations and a disease may be more difficult to establish than the influences men can be subjected to. Besides, women do more housework than men, also when they are formally employed. From an ergonometric point of view, housework resembles much of the work that women do in their jobs. When a disease happens, it may be difficult to determine whether it stems from the work and not from other tasks. In cases of multiple causes, there may be a further gender bias. Recent research has shown that while men tend to give explanations in a simple cause-effect manner, women more often use multi-causal explanations, where one cause does not necessarily have precedence over another. Thus legislation demanding clear linkage in a mono-causal way to the work situation may therefore apply more to men's perceptions than to women's.

2.2.4 Pregnant women and work

The increase that has recently been seen in women's participation in employed work also includes pregnant women; more than three quarters of pregnant women in Norway were formally employed in a survey conducted in 1991* It has been estimated that approximately 7 per cent of all working women will at one point in time be pregnant. Pregnancy and paid work is thus an issue both for individual women and for workplaces.

Pregnancy itself is not regarded as a disease - and pregnancies should not be

** Strand, K. et al: Graviditet i arbeidslivet. (Pregnancy among working women). In: Schei, B. et al (eds.): Kvinnemedisin. (Female Medicine) Ad Notam Gyldendal, Oslo 1993*

medicalized. This notion, however, creates some dilemmas as to the rights of pregnant women to paid sick leave, a right which has gradually been restricted. Pregnant women have the same right as everybody else when they contract regular diseases. They are also entitled to paid leave if they experience complications in the pregnancy, like hypertension, and in multiple pregnancies. But what is perceived as «normal pregnancy complaints» are not accepted as reasons for paid sick leave. It has been defined what the difference is between normal pregnancy complaints and complications, but the final assessment must necessarily be a subjective one done by the doctor or the Government Insurance Scheme authorities.

During the last 12 weeks of the pregnancy there are only a few causes that qualify for sick leave, and during the two weeks before term sick leave is not at all accepted - if a woman is sick then for any reason, she has to start her maternity leave.

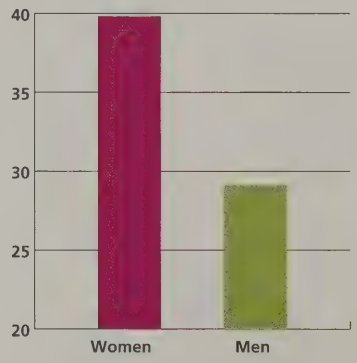
It was an increase in sick leave among pregnant women that led to the restrictions in the right to sick leave. It happened after it was shown that a high number of women went on sick leave for a long time during their pregnancy, and the cost escalated. The imposed restrictions in granting sick leave to pregnant women have met some criticism. Lower back pain, nausea and fatigue can be incapacitating, but are regarded as «normal complaints». Some critics claim that the concern is for the foetus, not for the woman.

There are cases where the nature of the work qualifies women for paid leave during pregnancy. That is when the work involves irradiation, chemical exposure and other harmful effect on the foetus.

2.3 Musculo-skeletal disorders

While the prevalence of musculo-skeletal problems among men is reported to have been constant over the last few years, such problems are reported increasingly often for women. A large number of persons receive disability pension for lower back pain, generalized muscular pain and related diseases. This illustrates the high disease burden and a high public cost. Despite the fact that more applications concerning women are turned down than for men, the total number of women on disability pension for these causes remains high. No other category of diseases has such a high prevalence as a cause for disability pension.

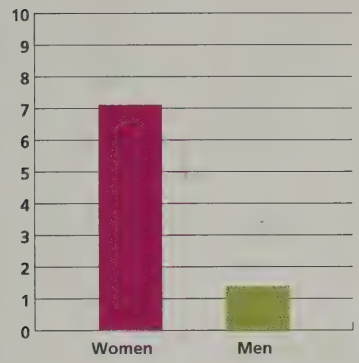
Percentage of persons with musculo-skeletal diagnoses who were granted disability pension in 1993



Source: Social Security Statistics Yearbook 1994, National Insurance Administration

A major part of the difference between men and women is made up by fibrositis and myalgia. These are so-called ill-defined conditions.

Percentage of all persons granted disability pension in 1993 with the diagnoses fibrositis and myalgia.



Source: Social Security Statistics Yearbook 1994, National Insurance Administration

There are many speculations as to why more women than men suffer from diffuse muscular pain. We could also turn the question around, and ask why we still know so little about a condition that is so prevalent among women, so little that we often resort to calling them «ill-defined».

2.4 Mental disorders

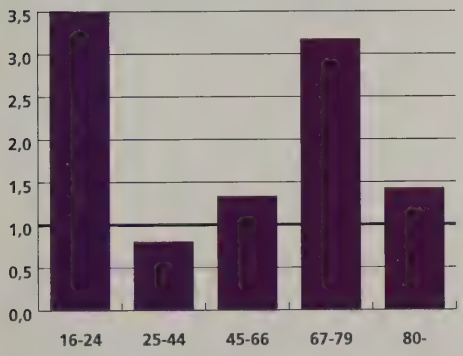
By a number of indicators, women appear to have more mental problems than men.

Self-reported mental ill-health, as recorded in a study from 1991, shows that in most age groups women suffer more mental problems than men, and elderly women are particularly prone: more than three times as many women than men report having a nervous condition. Women use tranquillizers more often than men, except for the age group 25 to 44 years.

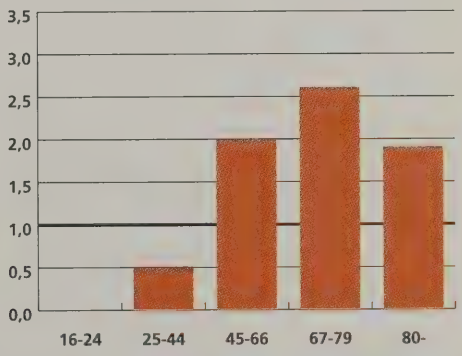
Data on hospitalization in mental hospitals and in mental wards in general hospitals give the same overall picture of women having more mental problems than men. The only exception again is young men.

Mental health. In need of help in various categories. Females/males ratio.

Ratio between women and men in reporting mental health problems.

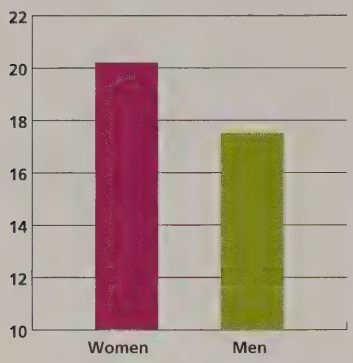


Ratio between women and men in use of tranquillizers.



Source: Official Statistics of Norway: Survey of level of living 1991. Statistics Norway,,1992.

Percentage of persons who were granted disability pension in 1993, with mental diagnoses.



Source: Yearbook of Statistics on Social Security. The National Insurance Administration 1994.

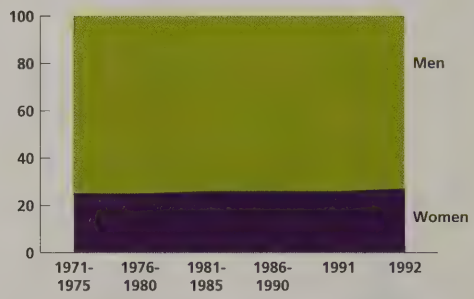
A look at causes for disability pension reveals some gender differences, but they are not as striking as other indicators of mental health.

There is one important indicator where men score higher than women, namely **suicide.** Moreover, a substantial increase is recorded, particularly among men. The higher incidence of suicide runs parallel with a higher frequency of violent death from other causes.

We do not have fully reliable data on attempted suicide, but it has been estimated that there are 10 attempts to each suicide. In contrast to suicide, attempts are more common among women than men*.

Although the **eating disorders** anorexia and bulimia have been known for centuries, they have only recently been acknowledged as a public health problem. The accompanying emotional disturbances can range from lack of concentration and depression to sleeping disturbances. Eating disorders strike primarily young people, from 12 to 25 years of age. Athletes and ballet dancers are particularly prone; in one study, 18 per cent of top female athletes had serious eating disorders**.
Community-based studies indicate that 5-10 per cent of girls and 1-5 per cent of boys in their teens have significant symptoms.

Suicide rate by sex and age since 1971.



Source: Causes of Death 1992, Main Tables. Statistics Norway 1994.

* *Sosialt utsyn, Statistics Norway, Oslo 1993*

** *Sundgot-Borgen, J.: Spiseforstyrrelser blant idrettsutøvere. (Eating disorders among Athlets). Norwegian University of Sport and Physical Education & Directorate of Health, 1991.*

3. TOWARDS GENDER SENSITIVITY IN HEALTH CARE

Health care is in constant change, and much has happened in order to make health services more sensitive to the needs of women. There are many players involved, and we will discuss some changes and challenges with respect to the knowledge on which health is built and on how health services are organized. Health care also depends on political support and decisions. Politicians, the media and the general public are instrumental in sustaining health services and in bringing about changes.

3.1 Generating gender-sensitive knowledge

The scientific basis of medical practice draws on many disciplines. For a long time it was perceived that knowledge was objective and gender neutral. But the notion of neutrality has been challenged, among others by women researchers. We will here give some examples.

3.1.1 Revelation of bias in biological research

Pharmacokinetic tests (i.e. testing the metabolism of a drug in the body) are often performed on laboratory animals, mainly rats. In order to create standard conditions that can be compared, female rats are normally excluded from such tests, because of fear that their menstrual cycle might interfere with the results. It has simply been presumed that female individuals have the same metabolism as males, a notion that recently has been shown to be false. When drug development has come to the stage of testing on humans, women have often been excluded. This has been either for fear of hormonal interference with the results, or because women might get pregnant while taking a drug with uncertain, and possibly harmful, effect on the foetus. When it comes to interference with drug metabolism, women differ from men in more ways than height and weight, e.g. on the distribution of body fat, and the hormonals. This may imply that the dosage for women in some cases should differ from those of men. This type of knowledge is overlooked if scientific experiments do not include both females and males.

3.1.2 Need for gender specific data

Epidemiological studies and monitoring are often insufficient in giving data on gender. Therefore, specific problems faced by either women or men can be hidden in the overall data, resulting in lost opportunities for analysis and intervention.

3.1.3 Specific health problems of women

Specific problems facing women have been unveiled by research. We have already mentioned research on sexual violence. It has proved important that women are involved in data collection, in order to build rapport and confidence with the persons who are affected. Infertility and various mental problems are other examples of health problems that have been researched in a similar way.

3.1.4 Research on the communication process and on «ill-defined» conditions

Innovative research has been done on the communication between patients and health personnel. Such work has questioned the long held view of the patient holding «subjective views» while the health worker is an «objective observer». The validity of the view of the patients has been re-examined in the light of the power balance in the process. It has been shown that patients can have much insight into the complex causes of their problem, and this understanding can be used to find solutions. This is especially crucial for the so-called ill-defined conditions. These conditions are ill-defined in the sense that they do not fit into the existing diagnostic entities. But it has been shown that they can be very well defined by the sufferers, who are aware of the multi-factor causes. In this category of disease diffuse muscular pain and fibrositis are typical examples. The mere fact that considerably more women than men have such «ill-defined conditions», indicates that the diagnoses categories have been constructed more from men's perspective than from women's.

Many health workers feel intuitively that traditional disease categories do not fit women's problems very well. It has proved important to translate such intuitive notions into science. It has resulted in the development of methods for better communication with patients and more recognition of women's health problems. In the future, it can hopefully lead to better treatment and improved quality of life.

More women than men are hospitalized, and most hopsital staff are women.

3.2 Organization of health care

3.2.1 Women as users of health services

Like in other countries, women in Norway use health services to a greater extent than men do. This goes for both curative and preventive purposes. Presently, three out of five consultations in primary health are for women, and above the age of 10, the rate of women attending consultations within primary health care is higher for women than for men in all age groups. Besides coming on their own behalf, there are more women than men who accompany children, or others, to health care. Women, to a greater extent than men, take care of and have responsibility for family members and for the overall functioning of the home and local community.

3.2.2 Gender perspetive in general screening programmes

Screening has become an important task for the health services, and takes up a lot of resources. Women go to the health services for screening during pregnancies and for contraception. Screening for breast cancer and cervical cancer is taking place according to central guidelines. But they also also invited to general screening programmes.

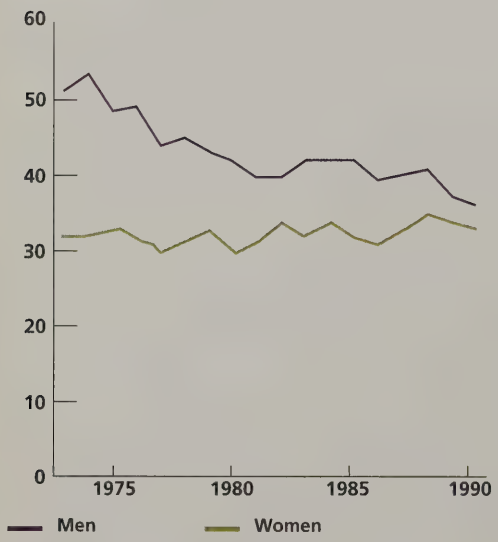
In the early '70s, large screening programmes for cardiovascular diseases were put in place, with the double intention of research and intervention. They showed that the best age group to screen and to implement intervention measures for was 40. The Oslo Study, which included only men, gained international attention when it was proved that a modest intervention had an impact on the diet and on smoking, and even on mortality.

Later, these screening programmes have been extended to women. They are being invited at the same age as men, despite the fact that women tend to get the disease 15-20 years later than men. Standard male procedure should not, without modification, be used for women. For example, the threshold where cholesterol poses a significant risk for increased mortality is higher in women than in men. On the other hand, diabetes and rise in triglycerides seem to be more strongly associated with cardiovascular diseases for women than for men. There are also threats that are unique for women, like the use of oestrogen substitution after menopause.

3.2.3 Women and smoking: failing campaigns, or other factors?

Smoking is a serious health hazard, and the authorities have made serious efforts to reduce prevalence of smoking. It seems, however, that they have been much more successful with respect to men than to women. While the percentage of daily smokers among men fell from 51 per cent in 1973 to 37 per cent in 1993, the percentage of women has remained stable, around 30 per cent, over the same period of time.

Daily smookers
women and men 16-74 years
1973 - 1990



Source: National Council on Tobacco and Health

3.2.4 Providing health care for all: a decentralized, public system

In order to describe the present emphasis on decentralized, primary health care, we will give a historic overview.

Norway introduced the system of government employed physicians as early as 1603, with "District Doctors". The tasks of these physicians were, in addition to giving treatment, to prevent diseases and to monitor some aspects of health. This system of "District Doctors" has been the cornerstone of medical work in the country over the past few centuries. Specialized and hospitalized care came much later, with the increase in scientific knowledge and improved technology. The specialized services gradually gained prestige, and took up more and more of the resources. The system of primary health care was maintained, but was marginalized over time.

In the late 1960s and '70s, primary health care gained increased international attention, and the traditional system of "District Doctors" underwent a renaissance in Norway. Maintaining primary health care in the districts was seen as an important prerequisite for keeping a decentralized population structure, and the central government was willing to allocate resources to its upkeep. Extra monetary incentives and increased

opportunities for continued education in order to maintain high professional standards were introduced, making primary health care more attractive. Research had been largely confined to high-tech hospital work, but at that time primary care caught the interest of researchers, and the authorities saw the importance of this and allocated money for it.

In the late '70s and early '80s, decentralization became a hot political issue, as decentralization of political power was seen as strengthening democratization. In 1984, the political and administrative responsibility for primary health care devolved to the municipal authorities, with guidance from central government. Simultaneously the concept of primary health care was extended to include, *inter alia*, various kinds of home care, school health and physiotherapy.

3.2.5 Women's role in giving priority to certain health issues

For many years there were no female doctors in the "District Doctor" system. The first Norwegian female doctor graduated in 1893. Other women followed suit, but the medical profession has been dominated by men until the most recent decades.

But women have by no means been uninterested in health matters. In the beginning of this century a number of philanthropic associations were created. The issue of women's rights came to the forefront in an organized way. The pioneers who fought for the enfranchisement of women were also the ones who first advocated the right to regulate fertility. They realized early on that in order for women to have true reproductive rights, the rights of children must be secured, regardless of the marital status of the mother, and the fight for the rights of children went hand in hand with the feminist movement.

In 1924 the first clinic to counsel women with respect to reproduction and childcare opened in Oslo. A private organization was in charge, and promoting the right to make informed reproductive choices was its main task. The clinic was politically controversial in the beginning, as many felt that giving women reproductive choices would promote promiscuity and be a threat to public morals. But soon the critics had to give in. Such clinics proved their value, while the worries were not confirmed. The health authorities also saw their benefits, and gradually took over the establishment and the running of such clinics. This was important because the financial basis for the clinics was secured. The recognition was also important, and it represented a shift in what was seen as public responsibilities in health.

Very specific problems have also been identified and handled by voluntary women's groups. One example is breastfeeding. While the benefits of breastfeeding for the survival of children was recognized early, very few professionals reacted when the prevalence of breastfeeding started declining around 1920. The decline was at first slow, but became more rapid, please see page 35. The trend followed the pattern in many other industrialized countries. The decline can be seen as an unintended side-effect of the practice of feeding the baby according to the clock instead of when the babies cry. But when breastfeeding went down, lay women took action. In 1968 the Norwegian Association of Breastfeeding was formed, an association which is still

active and strong. It constitutes a network of mother-to-mother support groups, spread all over the country. Mothers who run into difficulties in breastfeeding can turn to experienced women for counselling. Research has been carried out by members of the association, and there is cooperation between the breastfeeding association and the authorities in areas like monitoring the Code of Marketing of Breast Milk Substitutes, in promoting breastfeeding generally, and more recently with the Baby Friendly Hospital Initiative. As a result of all these efforts, the decline in breastfeeding prevalence in Norway was only temporary.

In the wake of the feminist era, domestic violence gained interest. Again, it was groups of women who were pioneers in identifying and tackling the problem. In 1977, the first shelter for battered and raped women was opened. Since then, such shelters have been opened all over the country. Some centres that specialize on the problems of victims of incest have also been opened. In 1993, a total of 2,557 women and 1,713 children used the shelters, staying an average of 13 nights. Lay people take turns working at the shelters, and the government allocates some money for the employment of a coordinator. Clients are referred to the police, Social Services or to health care, depending on their needs and wishes. The shelters have also provided important pieces of research, helping to make visible a long existing but much neglected problem, also among professionals. Women's organizations have proved that something can be done, and there is growing pressure that the health services should take greater responsibility.

By revealing neglected areas, women's volunteer work has challenged the idea of what the health services should deal with. By proving that it is possible to do something about problems, they have set an example. But it is a requirement that the authorities are responsive to actions taken by women, and are willing to change. The research that has been carried out has been important in the work of documenting problems and interventions, and funds for such research have mostly come from the authorities.

3.3 Politics of health: many achievements, but important challenges remain

The level of health in a society depends on a lot on factors outside the health services. Standard of living, environment and education are some examples. For women's health, it becomes important to what extent equity has become a reality.

Health care is of course also important. Since women have not reached the same level of income and prestige as men, it is especially important to women that health care is affordable and accessible. We have seen that there is a need to adapt health services more to the needs of women. Reproductive and sexual health and rights appear to be an area where major achievements have been made, and occupational health is among the areas that merit more attention and improvement.

Laws and regulations that guarantee women and their children subsistence in cases of divorce, widowhood and in single parenthood have improved health and quality of life for women. Reproductive choices of women can only be possible if they do not have to rely on men economically.

But there are still challenges, and inequalities need to be addressed. Many families with a single parent struggle to make ends meet, and the majority of such parents are women. Because women more often than men have diseases that do not fit into a well-accepted diagnostic category, full social security is more difficult to attain for women than for men.

A public retirement pension is granted to people above the age of 67. Everybody gets a minimum pension, but an addition is given according to the length of time a person has worked. Since more men than women are employed, and since a large number of women still work part time, the remuneration for women pensioners is lower than for men.

During the years that women have been more strongly represented politically than before, important legislative changes to facilitate the combination of work and family life have taken place. Longer parental leave and incentives for fathers to take more responsibility for their young children have been among the measures. There has also been a significant increase in the number of places in day-care centres for children. Such progress has been given priority even in times of economic recession.

Organizations representing various interest groups have a considerable influence on how politics are formulated. Since 1970, the radical women's movement has been particularly vocal. Relations between the organizations and the authorities have of course given rise to some frustration and anger - anything else would be unnatural. But all in all there is fruitful cooperation and open dialogue, worthy of a functioning democracy. Media play an important role in the public debate, which is important for how societal values are created and changed.

CONCLUSION

Women in Norway have reached a high standard of health measured by conventional indicators. Many factors have contributed to this fortunate situation. Generally good socio-economic conditions and stable political rule, with social security and a high degree of equity, have made an important base for improved health. Public health care covering everybody living in the country, with private services playing a negligible role, is of central importance for health security.

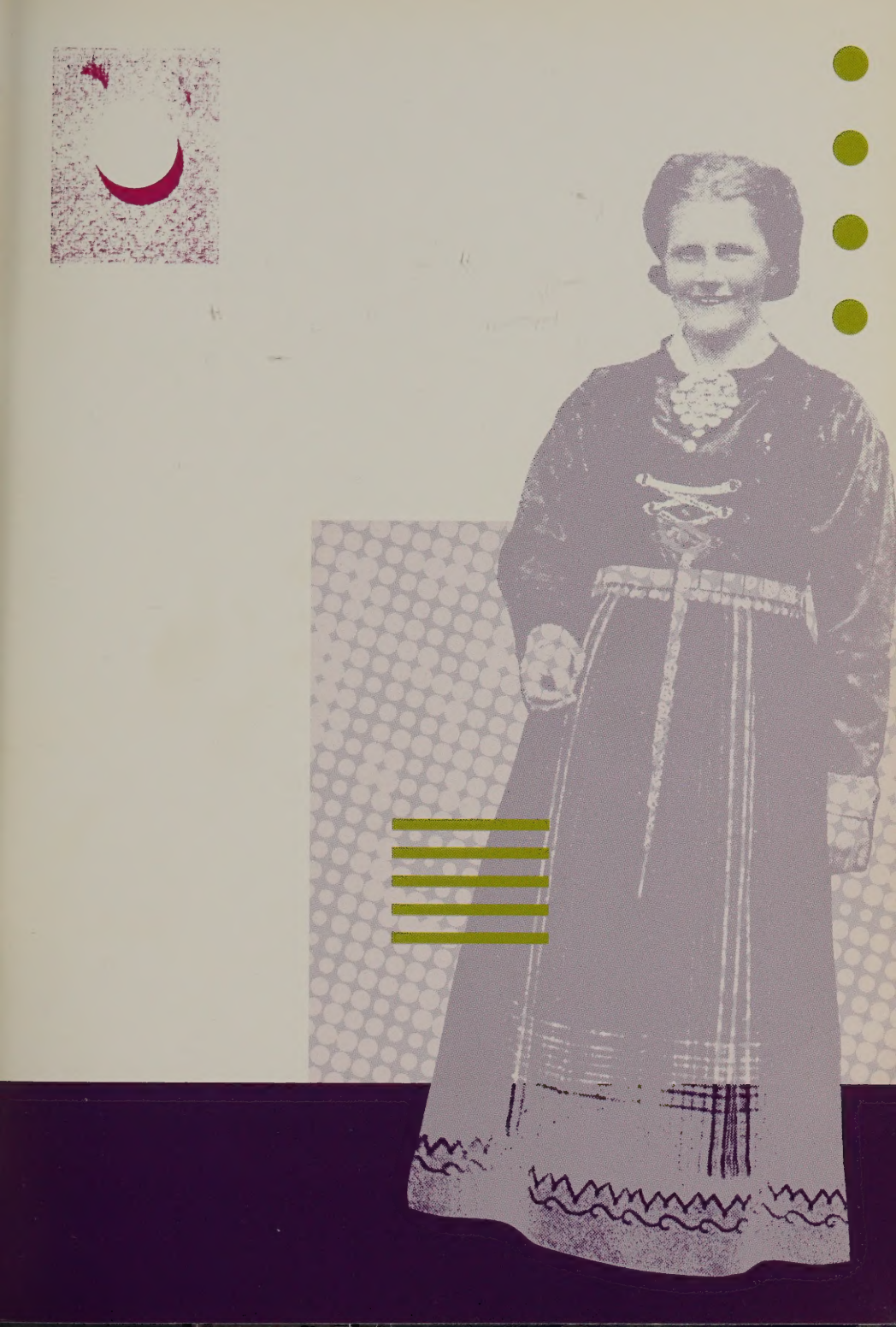
And yet there are inequities. Social differences do exist, and geographical differences seem inevitable in such a varied country as Norway. Gender inequalities are by no means erradicated. While women have entered the labour market and are now in the majority in higher education, men still hold the most prestigious and powerful posts in the academic world and in private business, and still have generally higher income than women. While women have gained much political power, women's views and women's needs are still less visible than men's.

As in other industrialized countries, women in Norway have lower mortality but higher morbidity than men. But diseases that are more prevalent among women tend to have low prestige, and women get less recognition when they are incapable of fending for themselves due to diseases.

Reproductive and sexual health and rights is an area where great achievements have been made. Maternal mortality is among the lowest in the world, and reproductive health care is fully integrated in health services. The level of sexually transmitted diseases is low and decreasing, and heterosexual transmission of HIV of domestic origin is so far extremely rare.

On the other hand, there are important challenges and needs for improvement. Occupational health and musculo-skeletal diseases stand out as areas where still much has to be done.

Health care is built on science and knowldge. But what we call knowledge is not gender neutral. More quantitative information on women is required, in the form of gender specific data. Recently progress has been made in doing qualitative research on women's views and perceptions, which is a major step forward in providing a better basis for health care. Interest groups from a very vocal grassroot have been important in pushing specific health problems onto the agenda. An open dialogue with the authorities is central in providing health care based on democratic principles.



Norwegian Board
of Health

World Health
Organisation